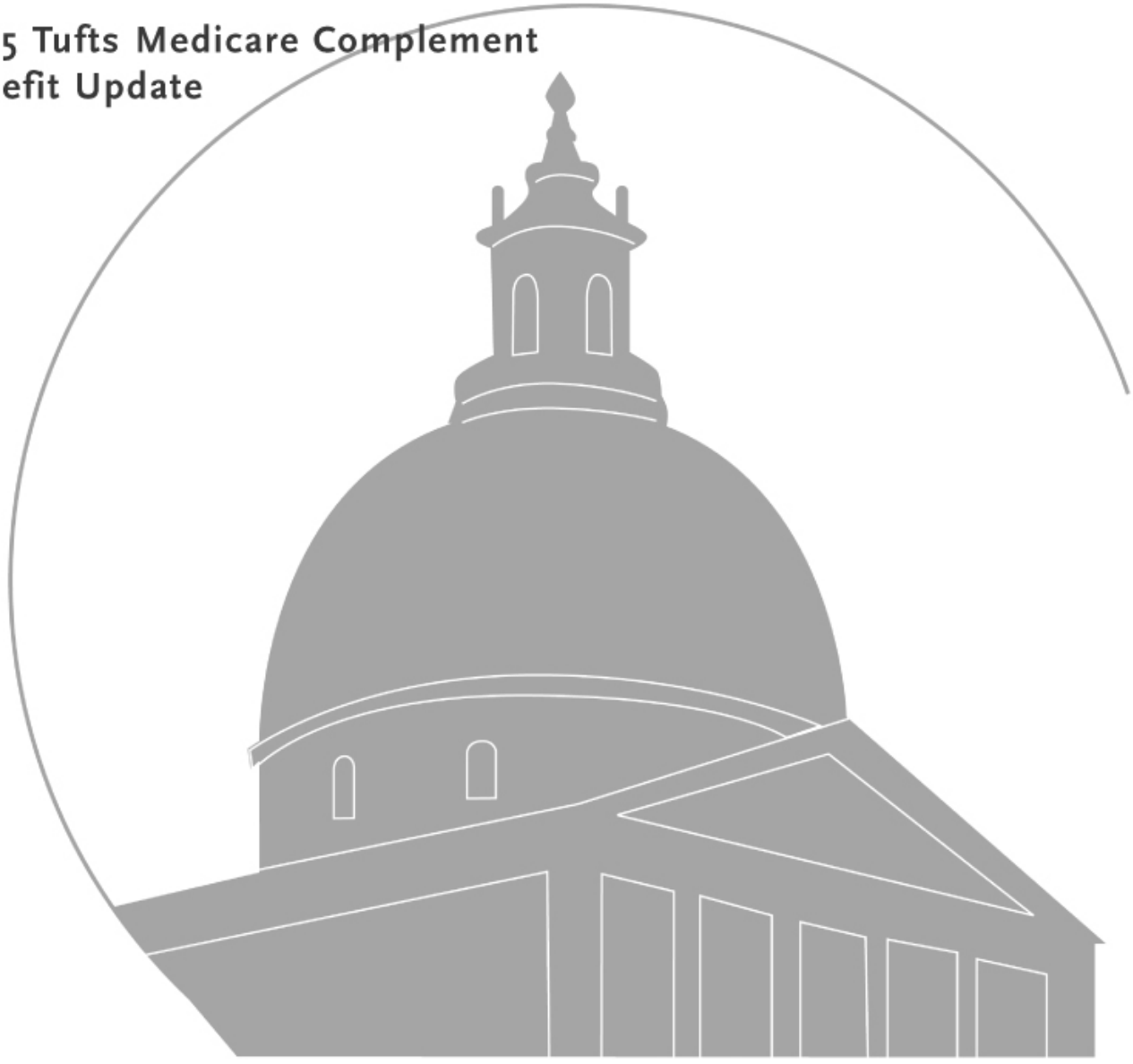
TUFTS Health Plan

Commonwealth of Massachusetts
Group Insurance Commission

> 2005 Tufts Medicare Complement Benefit Update



GIC TMC Benefit Update (2005)

The information below amends or clarifies the language in the following Tufts Medicare Complement ("TMC") documents:

- GIC TMC Evidence of Coverage (EOC) - 7-2003 edition; and
- GIC TMC Benefit Update - 7-2004 edition.

This 2005 GIC TMC Benefit Update includes *benefit clarifications* and other important information about your health care coverage under the Group Insurance Commission's Tufts Health Plan TMC option. You should put these pages in your TMC Evidence of Coverage for easy reference. If you have any questions, please call a Member Services Coordinator at **1-800-870-9488**.

You should put these pages in your TMC Evidence of Coverage for easy reference.

2005 Updates:

This section describes benefit clarifications and benefit revisions to your health care coverage under the GIC's Tufts Health Plan TMC option. These changes and revisions are effective as of July 1, 2005, unless otherwise indicated below.

Benefit Revisions:

•Chapter 3 – Exclusions from Benefits

Effective July 1, 2005, the following exclusion is added to the "Exclusion of Benefits" section on pages 3-38 through 3-41 of the 2003 EOC:

- Infused medications and their administration are not covered in the home setting (home infusion) under this TMC plan, unless Medicare covers the infused medication and/or its administration as the primary payor. Tufts HP will cover any remainder of the cost up to the Medicare allowed amount.

•Appendix B – List of Non-Covered Drugs

Effective January 1, 2005, the list of "Non-Covered Drugs with Suggested Alternatives" found in Appendix B of your 2003 Evidence of Coverage (as amended in Appendix B of the 2004 Benefit Update) has been changed to read as follows:

Appendix B – Non-Covered Drugs With Suggested Alternatives

This list of non-covered drugs is effective January 1, 2005 and may change during the year. Drugs may be added to this list for safety reasons, when a new drug comes to market, or if a prescription drug becomes available over-the-counter.

IMPORTANT NOTE: Please see the Plan's Web site at **www.tuftshealthplan.com** for the most current list or call a Member Services Coordinator.

Brand Name	Suggested Alternatives
AcipHex	omeprazole (Tier-1, lowest *Copayment*) or Nexium or Prevacid (Tier-3, highest *Copayment*)
Atacand	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Atacand HCT	Diovan HCT or Hyzaar (Tier-3, highest *Copayment*)
Avalide	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Avapro	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Axid	nizatidine (Tier-1, lowest *Copayment*)
Beconase AQ	Nasacort AQ, Flonase, Nasonex, or Rhinocort Aqua (Tier-2, middle *Copayment*)
Bright Beginnings Prenatal Supplement Bars	prenatal vitamins plus iron (Tier-1, lowest *Copayment*)

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·Appendix B – Non-Covered Drugs With Suggested Alternatives - continued

Brand Name	Suggested Alternatives
Capoten	captopril (Tier-1, lowest *Copayment*)
Clarinex	loratidine and chlorpheniramine (OTC, not covered); Allegra or Zyrtec (Tier-3, highest *Copayment*)
Dynacin	minocycline hcl (Tier-1, lowest *Copayment*)
EC Naprosyn	enteric-coated naproxen (Tier-1, lowest *Copayment*)
Flagyl 375 mg, Flagyl ER	metronidazole tablets 250mg, 500mg (Tier-1, lowest *Copayment*)
Genotropin	Humatrope, Norditropin, Nutropin, Protropin, Saizen (Tier-2, middle *Copayment*)
Klonopin	clonazepam (Tier-1, lowest *Copayment*)
Lidex, Lidex-E	fluocinonide and fluocinonide E (Tier-1, lowest *Copayment*)
Lopressor	metoprolol (Tier-1, lowest *Copayment*)
Lupron 1mg/0.2mL vial and kit	leuprolide 1mg/0.2mL vial and kit (Tier-1, lowest *Copayment*) (prior authorization required for males age 25 and older)
Mevacor	lovastatin (Tier-1, lowest *Copayment*)
Micardis	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Micardis HCT	Diovan HCT and Hyzaar (Tier-3, highest *Copayment*)
Minocin	minocycline hcl (Tier-1, lowest *Copayment*)
Monistat Dual-Pak	miconazole or clotrimazole (OTC, not covered), or Diflucan 150mg (Tier-2, middle *Copayment*) or Terazol 3/7 (Tier-3, highest *Copayment*)
Monodox	doxycyline monohydrate (Tier-1, lowest *Copayment*)
Naprelan	naproxen sodium ext-rel (Tier-1, lowest *Copayment*)
Pepcid (except suspension)	famotidine (Tier-1, lowest *Copayment*)
Prevacid Naprapac	naproxen (Tier-1, lowest Copayment) plus omeprazole (Tier-1, lowest *Copayment*) or Nexium or Prevacid (Tier-3, highest *Copayment*)
Prilosec	omeprazole (Tier-1, lowest *Copayment*) or Nexium and Prevacid (Tier-3, highest *Copayment*) PLEASE NOTE: Prilosec is covered for *Members* 12 years of age and younger (Tier-3, highest *Copayment*)
Prinivil	lisinopril (Tier-1, lowest *Copayment*)
Prinzide	lisinopril/hydrochlorothiazide (Tier-1, lowest *Copayment*)
Relenza	amantadine (Tier-1, lowest *Copayment*)
Reprexain	hydrocodone/ibuprofen or ibuprofen alone (Tier-1, lowest Copayment)
Sporanox (capsules only)	Lamisil tablets (prior authorization required) (Tier-3, highest *Copayment*)
Tamiflu	amantadine (Tier-1, lowest *Copayment*)
Teveten	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Teveten HCT	Diovan HCT or Hyzaar (Tier-3, highest *Copayment*)
Valium	dazepam (Tier-1, lowest *Copayment*)
Vasotec	enalapril (Tier-1, lowest *Copayment*)
Vicoprofen	hydrocodone/acetaminophen combination products or ibuprofen alone (Tier-1, lowest *Copayment*)
Xanax/Xanax XR	alprazolam (Tier-1, lowest *Copayment*)
Zocor	Lipitor, Pravachol, or Crestor (Tier-2, middle *Copayment*)

•Chapter 3 - Prescription Drug Benefit

Effective July 1, 2005, the "Prescription Drug Benefit" provision found on pages 3-30 through 3-37 of the 2003 EOC (and as amended on page 4 of the 2004 Benefit Update) has been changed to read as follows:

Other *Covered Services* (outside of Medicare Parts A and B) - continued

PRESCRIPTION DRUGS COVERED BY MEDICARE

Prescription Drugs Covered By Medicare: Medicare provides coverage for certain prescription drugs used to treat certain medical conditions, including certain injectable medications, when those drugs are obtained and administered by a physician. The physician will bill Medicare, and if the drug meets Medicare's coverage guideline, Medicare will pay for 80% of the Medicare approved charge for that drug. Then, this TMC plan will pay the remainder of the Medicare approved amount for the drug.

Note: Infused medications and their administration are not covered in the home setting (home infusion) under this TMC plan, unless Medicare covers the infused medication and/or its administration as the primary payor. Tufts HP will cover any remainder of the cost up to the Medicare allowed amount.

For more information about coverage under this TMC plan, call Member Services at 1-800-870-9488.

COVERAGE FOR OTHER PRESCRIPTION DRUGS

Introduction: This section of the Prescription Drug Benefit describes coverage for other prescription drugs under this TMC plan, including certain injectable drugs not covered by Medicare. The following topics are included in this section to explain this prescription drug coverage: "How Prescription Drugs Are Covered"; "Prescription Drug Coverage Table"; "What is Covered"; "What is Not Covered"; "Pharmacy Management Programs"; and "Filling Your Prescription".

Capitalized words are defined in the Glossary in Appendix A.

How Prescription Drugs Are Covered: Prescription drugs will be considered Covered Services only if they comply with the Plan's Pharmacy Management Programs section described below and are: listed below under "What is Covered"; provided to treat an injury, illness, or pregnancy; Medically Necessary; and written by a Plan participating physician, except in cases of authorized referral or in Emergencies.

For a current list of covered drugs, please go the Plan's Web site at **www.tuftshealthplan.com,** or call a Member Services Coordinator at 1-800-870-9488.

For a list of non-covered drugs, please see Appendix B.

The Prescription Drug Coverage Table below describes your prescription drug benefit amounts.

- Tier-1 drugs have the lowest Copayment; many generic drugs are on Tier-1.
- Tier-2 drugs have the middle Copayment.
- Tier-3 drugs have the highest Copayment.

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•Prescription Drug Benefit - continued

Other *Covered Services* (outside of Medicare Parts A and B) - continued

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

Where to fill prescriptions:

You can fill your prescriptions at any Plan designated pharmacy. Plan designated pharmacies include:

- for the majority of prescriptions, most of the pharmacies in Massachusetts and additional pharmacies nationwide; and
- for a select number of drug products, a small number of special designated pharmacy providers. (For more information about the Plan's special designated pharmacy program, see "Plan Pharmacy Management Programs" earlier in this Prescription Drug Benefit section.) If you have questions about where to fill your prescription, call the Member Services Department at 1-800-870-9488.

How to fill prescriptions:

- Make sure the prescription is written by a Plan participating physician, except in cases of authorized referral or in Emergencies.
- When you fill a prescription, provide your Member ID to any Plan designated pharmacy.
- If the retail cost of your prescription is less than your Copayment, then you are responsible for the actual retail cost.
- If you have any problems using this benefit at a Plan designated pharmacy, call the Member Services Department at 1-800-870-9488.

  Important: Your prescription drug benefit is honored only at Plan designated pharmacies. In cases of Emergency, please call the Member Services Department at 1-800-870-9488 for instructions about submitting your prescription drug claims for reimbursement.

Filling Prescriptions for Maintenance Medications:

If you are required to take a maintenance medication, the Plan offers you two choices for filling your prescription medications:

- you may obtain your maintenance medication directly from a Plan designated retail pharmacy; or
- you may have most maintenance medications# mailed to you through a Plan designated mail services pharmacy.

#The following may not be available to you through a Plan designated mail services pharmacy:

- medications for short term medical conditions;
- certain controlled substances and other prescribed drugs that may be subject to exclusions or restrictions;
- medications that are part of the Plan's Dispensing Limitations program; or
- medications that are part of the Plan's Special Designated Pharmacy program.

Note: Your Copayments for maintenance medications are shown in the Prescription Drug Coverage Table below.

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•Prescription Drug Benefit - continued

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued	
PRESCRIPTION DRUG COVERAGE TABLE	
Description	**Coverage**
DRUGS OBTAINED AT A RETAIL PHARMACY: Covered prescription drugs (including both acute and maintenance drugs), when you obtain them directly from a Plan designated retail pharmacy.	**Tier-1 drugs**: • $8 for up to a 30-day supply • $16 for a 31-60 day supply • $24 for a 61-90 day supply **Tier-2 drugs:** • $20 for up to a 30-day supply • $40 for a 31-60 day supply • $60 for a 61-90 day supply **Tier-3 drugs:** • $35 for up to a 30-day supply • $70 for a 31-60 day supply • $105 for a 61-90 day supply
DRUGS OBTAINED THROUGH A MAIL SERVICES PHARMACY: Most maintenance medications, when mailed to you through a Plan designated mail services pharmacy.	**Tier-1 drugs**: • $16 for up to a 90-day supply **Tier-2 drugs:** • $40 for up to a 90-day supply **Tier-3 drugs:** • $70 for up to a 90-day supply

Note: If you fill your prescription in a state that allows you to request a brand-name drug even though your physician authorizes the generic equivalent, you will pay the applicable Tier Copayment plus the difference in cost between the brand-name drug and the generic drug.

•Prescription Drug Benefit - continued

Other *Covered Services* (outside of Medicare Parts A and B) - continued

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

What Is Covered:

The Plan covers the following under this Prescription Drug Benefit:

- Prescribed drugs (including hormone replacement therapy for peri and post-menopausal women) that by law require a prescription and are not listed under "What is Not Covered" (see "Important Notes" below).
- Insulin, insulin pens, insulin needles and syringes; oral diabetes medications that influence blood sugar levels; and urine glucose and ketone monitoring strips. Please see Part B – Benefits (see page 3-19 of the 2003 EOC, as amended by page 4 of the 2004 Benefit Update) for more information about coverage for lancets and blood glucose strips, when provided by your Medicare Benefit instead of this Prescription Drug Benefit under your TMC plan;
- Retin-A ® and similar prescription drug products for individuals through the age of 25;
- Oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription#;

  # Note: This Prescription Drug Benefit only describes coverage for oral contraceptives, diaphragms, and other hormonal contraceptives (e.g., patches, rings) that by law require a prescription. See "Family Planning" on page 3-23 of the 2003 EOC for information about other contraceptive drugs and devices that qualify as *Covered Services*. Please note that Depo-Provera is covered under that "Family planning" benefit.

- Prefilled sodium chloride for inhalation (both prescription and over-the-counter).

- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or HIV/AIDS which have not been approved by the FDA for that indication, provided, however, that such a drug is recognized for such treatment:
  - in one of the standard reference compendia;
  - in the medical literature; or
  - by the commissioner of insurance.

- Compounded medications, if at least one active ingredient requires a prescription by law.

Note: Certain prescription drugs products may be subject to one of the Pharmacy Management Programs described below.

•Prescription Drug Benefit - continued

Other *Covered Services* (outside of Medicare Parts A and B) - continued

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

What Is Not Covered:

The Plan does not cover the following under this Prescription Drug Benefit:

- Prescription and over-the-counter homeopathic medications.
- Drugs that by law do not require a prescription (unless listed as covered in the "What is Covered" section above).
- Drugs that are listed in Appendix B ("Non-Covered Drugs with Suggested Alternatives") at the end of this Evidence of Coverage.
- Vitamins and dietary supplements (except prescription prenatal vitamins).
- Topical and oral fluorides for adults.
- Cervical caps, IUDs, Levonorgestrel (Norplant®), and Depo-Provera (these are covered under your Outpatient care benefit found on page 3-23 of the 2003 EOC).
- Experimental drugs: drugs that cannot be marketed lawfully without the approval of the FDA and such approval has not been granted at the time of their use or proposed use or such approval has been withdrawn.
- Non-drug products such as therapeutic or other prosthetic devices, appliances, supports, or other non-medical products. These may be provided as described earlier in this chapter.
- Immunization agents. These may be provided under Preventive health care earlier in this chapter.
- Prescriptions written by physicians who do not participate in Tufts HP, except in cases of authorized referral or Emergency care.
- Prescriptions filled at pharmacies other than Tufts HP designated pharmacies, except for Emergency care.
- Smoking cessation agents.
- Drugs for asymptomatic onchomycosis, except for Members with diabetes, vascular compromise, or immune deficiency status.
- Retin-A ® and similar prescription drug products for individuals 26 years of age or older, unless Medically Necessary.
- Drugs which are dispensed in an amount or dosage that exceeds Tufts HP's established dispensing limitations.
- Compounded medications, if no active ingredients require a prescription by law.
- Prescriptions filled through an internet pharmacy that is not a Verified Internet Pharmacy Practice Site certified by the National Association of Boards of Pharmacy.
- Prescription medications once they become available over-the-counter. In this case, the specific medication is not covered and the entire class of prescription medications may also not be covered. For more information, call Member Services or check the Plan's Web site at **www.tuftshealthplan.com**.

•Prescription Drug Benefit - continued

Other Covered Services (outside of Medicare Parts A and B) - continued

COVERAGE FOR OTHER PRESCRIPTION DRUGS - continued

Pharmacy Management Programs:
In order to provide safe, clinically appropriate, cost-effective medications under this Prescription Drug Benefit, the Plan has developed the following Pharmacy Programs and Initiatives:

Dispensing Limitations Program:
The Plan limits the quantity of selected medications that Members can receive in a given time period, for cost, safety and/or clinical reasons.

Prior Authorization Program:
The Plan restricts the coverage of certain drug products that have a narrow indication for usage, may have safety concerns and/or are extremely expensive, requiring the prescribing physician to obtain prior approval from the Plan for such drugs.

Special Designated Pharmacy Program:
The Plan has designated special pharmacies to supply a select number of medications including medications used in the treatment of infertility, multiple sclerosis, hemophilia, hepatitis C and growth hormone deficiency. These pharmacies specialize in providing medications used to treat certain conditions, and are staffed with clinicians to provide support services for Members. Medications may be added to this program from time to time. Special pharmacies can dispense up to a 30-day supply of medication at one time.

Non-Covered Drugs with Suggested Alternatives*:
While the Plan covers over 4,500 drugs, a small number of drugs (less than 1%) are not covered because there are safe, effective and more affordable alternatives available. These non-covered drugs are listed in Appendix B. All of the alternative drug products are approved by the U.S. Food and Drug Administration (FDA) and are widely used and accepted in the medical community to treat the same conditions as the medications that are no longer covered.

New-To-Market Drug Evaluation Process:
The Plan's Pharmacy and Therapeutics Committee reviews new-to-market drug products for safety, clinical effectiveness and cost. The Plan then makes a coverage determination based on the Pharmacy and Therapeutics Committee's recommendation. A new drug product will not be covered until this process is completed – usually within 6 months of the drug product's availability.

IMPORTANT NOTES:

- If your physician feels it is *Medically Necessary* for you to take medications that are restricted under any of the Pharmacy Management Programs described above, he or she may submit a request for coverage. The Plan will approve the request if it meets Plan guidelines for coverage. For more information, you can call a Member Services Coordinator at 1-800-870-9488.
- The Plan's Web site has a list of covered drugs with their tiers. The Plan may change a drug's tier during the year. For example, if a brand drug's patent expires, the Plan may move the brand drug from tier 2 to tier 3 when the generic drug becomes available. Most generic drugs are available on tier 1.
- If you have questions about your prescription drug benefit, would like to know the tier of a particular drug, or would like to know if your medication is part of a Pharmacy Management Program, check the Plan's Web site at **www.tuftshealthplan.com**, or call a Member Services Coordinator at 1-800-870-9488.

Benefit Clarifications:

Chapter 3 – Covered Services:

•Patient care services provided as part of a qualified clinical trial

For purposes of clarification, the title for this benefit (found in "Other Covered Services (outside of Medicare Parts A and B)" on page 3-29 of the 2003 EOC) is changed to read as "Patient care services provided as part of a qualified clinical trial for the treatment of cancer".

•Exclusions from Benefits

For purposes of clarification, the following changes have been made to the "Exclusions from Benefits" section found on pages 3-38 through 3-41 of the 2003 EOC.

- The following items are added:
  - Treatment of vitiligo.
  - Vocational rehabilitation services and vocational retraining.
  - Exercise classes.
- The following sentence has been added to the exclusion related to examinations, evaluations, or services for educational purposes or developmental purposes (see page 3-41 of the 2003 EOC):

  The term "developmental" refers to a delay in the expected achievement of age-appropriate fine motor, gross motor, social, or language milestones that is not caused by an underlying medical illness or condition.

Changes to Other Provisions:

Chapter 1 – How Your HMO Plan Works:

· If you can't reach your PCP

This section, found on page 1-8 of the 2003 EOC, has been revised to read as follows:

Sometimes you may not be able to reach your PCP by phone right away. The table below explains what you should do if this happens.

IF…	THEN…
your PCP cannot take your call at once	always leave a message with the office staff or answering service. Wait a reasonable amount of time for someone to return your call. If your call is not returned, and this happens during a weekday, please call Member Services at **1-800-870-9488.** If this occurs during a night or weekend, you will need to follow the steps below for obtaining medical services after hours.
you need medical services after hours	please contact your PCP or a Covering Physician. Your PCP, or a Covering Physician, is available 24 hours a day, 7 days a week. If you need Inpatient mental health or substance abuse services after hours, please call 1-800-208-9565 for assistance.

Note: If you are experiencing a medical emergency, you do not have to contact your PCP or a Covering Physician; instead, proceed to the nearest emergency medical facility for treatment (see "When You Need Emergency or Urgent Care" below for more information).

· When referrals are not required

- The first item in this section (found on page 1-10 of the 2003 EOC), which refers to Emergency Care, is revised to read as follows:
  - Emergency Care in an Emergency Room or physician's office. (Note: If you are admitted as an Inpatient, you or someone acting for you must call your PCP or Tufts HP within 48 hours after receiving care. Notification from the attending physician satisfies this requirement.)
- In addition, the following item is added to this section (see page 1-10 of the 2003 EOC):
  - Urgent Care outside of the Tufts HP Service Area. (Note: You must contact your PCP after Urgent Care Covered Services are rendered for any follow-up care.)

Chapter 1 – How Your HMO Plan Works - continued:

· Procedure

For purposes of clarification, the "Note" in this section (see page 1-14 of the 2003 EOC) has been deleted.

· Inpatient mental health/substance abuse services

The final paragraph in this provision, found on pages 1-14 and 1-15 of the 2003 EOC, is changed to read as follows:

If you live in an area where the Plan's Designated Facilities are not available, the following will apply:

- You must call your PCP, who will arrange for you to receive Inpatient mental health/substance abuse services at a Tufts HP Provider.

· What to Do in an Emergency

For purposes of clarification, the title of this section (found on page 1-16 of the 2003 EOC) is changed to read as "When You Need Emergency or Urgent Care (whether you are in or out of the Tufts HP Service Area)". In addition, the following new provision is added to this section on page 1-16:

Guidelines for receiving Urgent Care

Follow these guidelines for receiving Urgent Care.

If you are in the Service Area

- Contact your PCP and tell him or her that you are a Tufts HP Member.
- Explain your problems as clearly as possible.
- If you are in the Tufts HP Service Area, your PCP will either provide you with care or will arrange for treatment or specialty care if necessary.

If you are outside the Service Area

- If you are outside of the Service Area, you may seek Urgent Care in a physician's office or the Emergency room.
- You or someone acting for you must contact your PCP to arrange for any necessary follow-up care.
- The Urgent Care Provider may bill Tufts HP directly or may require you to pay for the Urgent Care services at the time of service. If you are required to pay, Tufts HP will reimburse you up to the Reasonable Charge for Urgent Care services received outside of the Tufts HP Service Area. You are responsible for the applicable Copayment and any difference between what Tufts HP paid and what the Non-Tufts HP Provider charged for the service. Please see "Bills from Providers" on page 5-10 of the 2003 EOC for more information about how to get reimbursed for Urgent Care Covered Services received outside of the Service Area.

Important Note: If you are admitted as an Inpatient after receiving Urgent Care Covered Services, you or someone acting for you must call your PCP or Tufts HP within 48 hours after receiving care. (Notification from the attending physician satisfies this requirement.)

Chapter 1 – How Your HMO Plan Works - continued:

· What to Do When Traveling

The descriptions of coverage for Emergency care and Urgent Care outside of the Service Area, found in the table in this section (see page 1-17 of the 2003 EOC), are changed to read as follows:

Type of Service	Example	Coverage
Urgent Care	• a dislocated toe; • a cut that is not bleeding heavily but needs stitches; • symptoms of a urinary tract infection.	Covered
Emergency care	• a broken leg; • chest pains; • difficulty breathing; • heavy bleeding; • loss of consciousness; • vomiting blood; • severe pain.	Covered

Chapter 3 – Covered Services:

When health care services are Covered Services

The 5th item in this provision, found on page 3-2 of the 2003 EOC, is changed to read as follows:

- provided or authorized in advance by your PCP, except in an Emergency or for Urgent Care (see "When You Need Emergency or Urgent Care" on page 10 of this 2005 Benefit Update for more information);

Mental health and substance abuse services (Parts A and B)

· ***Outpatient mental health and substance abuse services (Part B)***

The footnote (#) describing Covered Services for Outpatient mental health and substance abuse services under Medicare Part B, found on page 3-21 of the 2003 EOC, is changed to include the following new item:

- Prior authorization is required for psychological testing and neuropsychological assessment services.

Other Covered Services (outside of Medicare Parts A and B)

· ***Family Planning***

The asterisked note (*) appearing in the description of Covered Services for contraceptives, found on page 3-23 of the 2003 EOC, is changed to include the following new item:

- Also, please note that, in certain circumstances, Depo-Provera is covered under the "Prescription Drug Benefit" (later in this chapter) instead of this "Family planning" benefit.

· ***Special Medical Formulas***

The description of this Covered Service, found on page 3-28 of the 2003 EOC, is changed to include the following new sentence:

(Prior authorization by an Authorized Reviewer may be required.)

Chapter 4 – When Coverage Ends:

· Obtaining a Certificate of Creditable Coverage

The following "Certificate of Creditable Coverage" provision is added to the "When Coverage Ends" provision in Chapter 4 of the 2003 EOC:

> The Group Insurance Commission will mail a Certificate of Creditable Coverage to each Subscriber upon termination in accordance with federal law. You may also obtain a copy of your Certificate of Creditable Coverage by contacting the GIC at (617) 727-2310, extension 1.

Chapter 5 – Member Satisfaction:

•Member Satisfaction Process

The "Member Satisfaction Process" section, found in Chapter 5 of the 2003 EOC (as amended on pages 5-9 of the 2004 Benefit Update) has been revised to read as follows:

Tufts Health Plan has a multi-level Member Satisfaction process including:

- Internal Inquiry;
- Member Grievances Process;
- Internal Member Appeals; and
- External Review by the Office of Patient Protection.

All grievances and appeals should be sent to Tufts HP at the following address:

Tufts Health Plan
Attn: Appeals and Grievances Dept.
705 Mt. Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193

All calls should be directed to Member Services at **1-800-870-9488**.

Internal Inquiry

Call a Member Services Coordinator to discuss concerns you may have regarding your healthcare. Every effort will be made to resolve your concerns within three (3) business days. If your concerns cannot be resolved within three (3) business days or if you tell a Member Services Coordinator that you are not satisfied with the response you have received from Tufts HP, we will send you a letter describing any options you may have, including the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accord with the timelines outlined below.

Tufts HP maintains records of each inquiry made by a Member or by that Member's authorized representative. The records of these inquiries and the response provided by Tufts HP are subject to inspection by the Commissioner of Insurance and the Department of Public Health.

Important Note: In many instances, we will ask you to direct your initial concern to Medicare (since Medicare will make the primary determination on your health care benefits). Information is available by contacting your local Social Security office or via the internet on the official Medicare Web site at **www.medicare.gov**.

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Member Grievance Process

A grievance is a formal complaint about actions taken by Tufts HP or a Provider. There are two types of grievances: administrative grievances and clinical grievances. The two types of grievances are described below.

It is important that you contact Tufts HP as soon as possible to explain your concern. Call a Member Services Coordinator who will document your concern and forward it to a Grievance Analyst in the Appeals and Grievance Department. Grievances may be filed either verbally or in writing. To accurately reflect your concerns, you may want to put your grievance in writing and send it to the address provided at the beginning of this section. Your explanation should include:

- your name and address;
- your Member ID number;
- a detailed description of your concern (including relevant dates, any applicable medical information, and Provider names); and
- any supporting documentation.

Important Note: The Member Grievance Process does not apply to requests for a review of a denial of coverage. If you are seeking such a review, please see the "Internal Member Appeals" section below.

Administrative Grievance Timeline

- If you file your grievance in writing, within five (5) business days after receiving your letter, we will notify you by mail that your letter has been received and provide you with the name, address, and telephone number of the Grievance Analyst coordinating the review of your grievance.
- If you file your grievance verbally, within forty-eight (48) hours we will send you a written confirmation of our understanding of your concerns. We will also include the name, address, and telephone number of the person coordinating the review.
- If your request for review was first addressed through the internal inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) business day internal inquiry process or earlier if you notify Tufts HP that you are not satisfied with the response you received during the Internal Inquiry process.
- If your grievance requires the review of medical records, you will receive a form that you will need to sign which authorizes your Providers to release medical information relevant to your grievance to Tufts HP. You must sign and return the form before Tufts HP can begin the review process. If you do not sign and return the form to Tufts HP within thirty (30) business days of the date you filed, Tufts HP may issue a response to your grievance without having reviewed the medical records. You will have access to any medical information and records relevant to your grievance which are in the possession and control of Tufts HP.
- Tufts HP will review your grievance, and will send you a letter regarding the outcome, as allowed by law, within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual written agreement between you or your authorized representative and Tufts HP.

Clinical Grievances

A clinical grievance is a complaint about the quality of care or services that you have received. If you have concerns about your medical care, you should discuss them directly with your Provider. If you are not satisfied with your Provider's response or do not wish to address your concerns directly with your Provider, you may contact Member Services to file a clinical grievance.

If you file your grievance in writing, we will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Grievance Analyst coordinating the review of your grievance. If you file your grievance verbally, we will send you a written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.

Tufts HP will review your grievance and will notify you in writing regarding the outcome, as allowed by law, within thirty (30) calendar days of receipt. The review period may be extended up to an additional thirty (30) days if additional time is needed to complete the review of your concern. You will be notified in writing if the review timeframe is extended.

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"Reconsideration"

If you are not satisfied with the result of the Clinical Grievance review process, you may request a "reconsideration". If you so choose, your concerns will be reviewed by a clinician who was not involved in the initial review process. Upon request for a reconsideration, your concerns will be reviewed within thirty (30) calendar days. You will be notified in writing of the results of the review.

Internal Member Appeals

An appeal is a request for a review of a denial of coverage for a service or supply that has been reviewed and denied by Tufts HP based on medical necessity (an adverse determination) or a denial of coverage for a specifically excluded service or supply.

It is important that you contact Tufts HP as soon as possible to explain your concern. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file an internal appeal. Appeals may be filed either verbally or in writing. If you would like to file a verbal appeal, call a Tufts HP Member Services Coordinator who will document your concern and forward it to a Member Appeals Analyst in the Appeals and Grievance Department. To accurately reflect your concerns, you may want to put your appeal in writing and send it to the address provided at the beginning of this section. Your explanation should include:

- your name and address;
- your Member ID number;
- a detailed description of your concern (including relevant dates, any applicable medical information, and Provider names); and
- any supporting documentation.

Appeals Timeline

- If you file your appeal in writing, within five (5) business days after receiving your letter we will notify you in writing that your letter has been received and provide you with the name, address, and telephone number of the Member Appeals Analyst coordinating the review of your appeal.
- If you file your appeal verbally, within forty-eight (48) hours of your call we will send you a written confirmation of our understanding of your concerns. We will also include the name, address, and telephone number of the Member Appeals Analyst coordinating the review of your appeal.
- If your request for review was first addressed through the internal inquiry process, and does not require the review of medical records, the thirty (30) calendar day review period will begin the day following the end of the three (3) day internal inquiry process or earlier if you notify Tufts HP that you are not satisfied with the response you received during the internal inquiry process.
- Tufts HP will review your appeal, make a decision, and send you a decision letter within 30 calendar days of receipt.
- The time limits in this process may be waived or extended beyond the time allowed by law upon mutual verbal or written agreement between you or your authorized representative and Tufts HP.

This extension may be necessary if we are waiting for medical records that are necessary for the review of your appeal and have not received them. The Appeals Analyst handling your case will notify you in advance if an extension may be needed. In addition, a letter will be sent to you confirming the extension.

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When Medical Records are Necessary

If your appeal requires the review of medical records you will receive a form that you will need to sign which authorizes your Providers to release to Tufts HP medical information relevant to your Appeal. You must sign and return the form before Tufts HP can begin the review process. If you do not sign and return the form to Tufts HP within thirty (30) calendar days of the date you filed your appeal, Tufts HP may issue a response to your request without having reviewed the medical records. You will have access to any medical information and records relevant to your appeal, which are in the possession and control of Tufts HP.

Who Reviews Appeals?

If the appeal involves a medical necessity determination, an actively practicing physician in the same or similar specialty as typically treats the medical condition, and who did not participate in any of the prior decisions on the case, will take part in the review. In addition, a Committee made up of Managers and Clinicians from various Tufts HP departments will review your appeal. A Committee within the Appeals and Grievances Department will review appeals involving non-covered services.

Appeal Response Letters

The letter you receive from Tufts HP will include identification of the specific information considered for your appeal and an explanation of the basis for the decision. A response letter regarding a final adverse determination (a decision based on medical necessity) will include: the specific information upon which the adverse determination was based; Tufts HP's understanding of your presenting symptoms or condition; diagnosis and treatment interventions, and the specific reasons such medical evidence fails to meet the relevant medical review criteria; alternative treatment options offered, if any; applicable clinical practice guidelines and review criteria; notification of the steps for requesting external review by the Office for Patient Protection; and the titles and credentials of the individuals who reviewed the case. Please note that requests for coverage of services that are specifically excluded in your Evidence of Coverage (EOC) are not eligible for external review.

An appeal not properly acted on by Tufts HP within the time limits of Massachusetts law and regulations, including any extensions made by mutual written agreement between you or your authorized representative and Tufts HP, shall be deemed resolved in your favor.

Expedited Appeals

Tufts HP recognizes that there are circumstances that require a quicker turnaround than the 30 calendar days allotted for the standard Appeals Process. Tufts HP will expedite an appeal when there is an ongoing service about to terminate or a service to be delivered imminently whereby a delay in treatment would seriously jeopardize your life and health or jeopardize your ability to regain maximum function. Should you feel that your request meets the criteria cited above, you or your attending physician should contact the Member Services Department. Under these circumstances, you will be notified of Tufts HP's decision within seventy-two (72) hours after the review is initiated. If you are an Inpatient in a hospital, Tufts HP will notify you of the decision before you are discharged.

If you have a terminal illness, we will notify you of Tufts HP's decision within five (5) days of receiving your appeal. If Tufts HP's decision is to deny coverage, you may request a conference.
We will schedule the conference within 10 days (or within 5 business days if your physician determines, after talking with a Tufts HP medical director, that based on standard medical practice the effectiveness of the proposed treatment or alternative covered treatment would be materially reduced if not provided at the earliest possible date). You may bring another person with you to the conference. At the conference, you and/or your authorized representative, if any, and a representative of Tufts HP who has authority to determine the disposition of the grievance shall review the information provided.

If the appeal is denied, the decision will include the specific medical and scientific reasons for denying the coverage, and a description of any alternative treatment, services or supplies that would be covered.

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Appeals Regarding Termination of Coverage

If your appeal concerns the termination of ongoing coverage or treatment, the disputed coverage shall remain in effect at Tufts HP's expense through completion of the internal appeals process. Only those services which were originally authorized by Tufts Health Plan and which were not terminated pursuant to a specific time or episode related exclusion will be continue to be covered.

If you are appealing coverage for services or Durable Medical Equipment (DME) that Tufts HP determined was not Medically Necessary: and your physician tells us that, in his or her opinion, the service at issue is Medically Necessary and certifies the specific immediate and severe harm that will result if you do not have coverage for the denied service or DME sooner than forty-eight (48) hours, we will provide coverage until we notify you of Tufts HP's decision.

Conference (Walk-in) Appeals

If the case involves an adverse determination (Medical Necessity determination), you, or your representative may also appear in person or by conference call to present your appeal. This is an opportunity for you to present additional information to the Committee that may be better communicated in person. If you would like to present your appeal in person, you must request this option. A Member Appeals Analyst will contact you to schedule a date and time to appear. You will have approximately twenty minutes to address the Committee. The Committee will not make a decision while you are present, but the Member Appeals Analyst will notify you of a decision after it has been made.

If You are Not Satisfied with the Appeals Decision

"Reconsideration"

In circumstances where relevant medical information (1) was received too late to review within the thirty (30) calendar day time limit; or (2) was not received but is expected to become available within a reasonable time period following the written resolution, you may choose to request a reconsideration. Tufts HP may allow the opportunity for reconsideration of a final adverse determination. If you request a reconsideration you must agree in writing to a new time period for review. The time period will be no greater than thirty (30) calendar days from the agreement to reconsider the appeal.

External Review by The Office of Patient Protection

The Office of Patient Protection, which is not connected in any way with Tufts HP, administers an independent external review process for final coverage determinations based on medical necessity (final adverse determination). Appeals for coverage of services specifically excluded in your EOC are not eligible for external review.

To request an external review by the Office of Patient Protection you must file your request in writing with the Office of Patient Protection within forty-five (45) days of your receipt of written notice of the denial of your appeal by Tufts HP. The letter from Tufts Health Plan notifying you of the denial will contain the forms and other information that you will need to file an appeal with the Office of Patient Protection.

You or your authorized representative may request to have your review processed as an expedited external review. Any request for an expedited external review must contain a certification, in writing, from a physician, that delay in the providing or continuation of health care services, that are the subject of a final adverse determination, would pose a serious and immediate threat to your health. Upon a finding that a serious and immediate threat to your health exists, the Office of Patient Protection will qualify such request as eligible for an expedited external review.

Your cost for an external review by the Office of Patient Protection is $25.00. This payment should be sent to the Office of Patient Protection, along with your written request for a review. The Office of Patient Protection may waive this fee if it determines that the payment of the fee would result in an extreme financial hardship to you. Tufts Health Plan will pay the remainder of the cost for an external review. Upon completion of the external review, the Office of Patient Protection shall bill Tufts HP the amount established pursuant to contract between the Department and the assigned external review agency minus the $25 fee which is your responsibility.

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External Review by The Office of Patient Protection - continued

You, or your authorized representative, will have access to any medical information and records relating to your appeal, in the possession of the Tufts HP or under its control.

If the subject matter of the external review involves the termination of ongoing services, you may apply to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending. The review panel may order the continuation of coverage where it determines that substantial harm to your health may result absent such continuation or for such other good cause, as the review panel shall determine. Any such continuation of coverage will be at Tufts HP's expense regardless of the final external review determination.

The decision of the review panel will be binding on Tufts HP.

Please note, if you are not satisfied with Tufts HP's member satisfaction process, you have the right at any time to contact the Commonwealth of Massachusetts at either the Division of Insurance Bureau of Managed Care or the Department of Public Health's Office of Patient Protection at:

Department of Public Health, Office of Patient Protection
250 Washington Street, 2nd Floor, Boston, MA 02108
Phone: 1-800-436-7757 / Fax: 1-617-624-5046/
Internet: www.state.ma.us/dph/opp

•Bills from Providers

The "Bills from Providers" section, found on page 5-10 of the 2003 EOC, has been revised to read as follows:

Bills from Providers

Medical Expenses

Occasionally, you may receive a bill from a Provider for Covered Services. Before paying the bill, contact the Member Services Department.

If you do pay the bill, you must send the following information to the Member Reimbursement Medical Claims Department:

- a completed, signed Member Reimbursement Medical Claim Form, which can be obtained from the Tufts HP Web site or by contacting the Member Services Department; and
- the documents listed on the Member Reimbursement Medical Claim Form that are required for proof of service and payment.

The address for the Member Reimbursement Medical Claims Department is listed on the Member Reimbursement Medical Claim Form.

Please note: You must contact Tufts HP regarding your bill(s) or send your bill(s) to Tufts HP within six months after the date you received **your first bill**. If you do not, the bill cannot be considered for payment.

If you receive Covered Services from a non-Tufts HP Provider, Tufts HP will pay you up to the Reasonable Charge for the services.

Tufts HP reserves the right to be reimbursed by the Member for payments made due to Tufts HP's error.

Pharmacy Expenses

If you obtain a prescription at a non-designated pharmacy, you will need to pay for the prescription up front and submit a claim for reimbursement. Pharmacy claim forms can be obtained by contacting a Member Services Coordinator or through the Plan's web site at **www.tuftshealthplan.com**.

Chapter 6 – Other Plan Provisions:

•Subrogation

For purposes of clarification, the "Subrogation" provision found on pages 6-1 and 6-2 of the 2003 EOC is changed as follows:

- Under "Tufts Health Plan's right of subrogation" provision, the reference to "a workers' compensation insurer" has been removed.
- The following new "Workers' Compensation" provision is added:

  Workers' compensation

  Employers provide workers' compensation insurance for their employees to protect them in case of work-related illness or injury.

  If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. Tufts Health Plan will not provide coverage for any injury or illness for which it determines that benefits are available under any workers' compensation coverage or equivalent employer liability, or indemnification law.

  If Tufts Health Plan pays for the costs of health care services or medications for any work-related illness or injury, Tufts HP has the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the Provider. If your Provider bills services or medications to Tufts HP for any work-related illness or injury, please contact the Member Services Department.

- Under "Tufts Health Plan's right of reimbursement" provision, the reference to "health care services and supplies" has been changed to read as "health care services, medications, and supplies".

Appendix A – Terms and Definitions:

· Terms and Definitions

The following changes have been made to the "Terms and Definitions" section in Appendix A (found on pages A-1 through A-9 of the 2003 EOC):

- The "Note" in the "Covered Services" definition on page A-2 of the 2003 EOC has been deleted.
- The following new paragraph is added to the "Emergency" definition on page A-3 of the 2003 EOC:

  Some examples of illnesses or medical conditions requiring Emergency care are severe pain, a broken leg, loss of consciousness, vomiting blood, chest pain, difficulty breathing, or any medical condition that is quickly getting much worse.

- The following "Notes" section is added to the "Provider" definition on page A-7 of the 2003 EOC:

  Notes:

  - With respect to Outpatient services for the treatment of alcoholism, Provider means an accredited or licensed hospital or any public or private facility or portion of that facility providing services especially for the rehabilitation of intoxicated persons or alcoholics and which is licensed by the Massachusetts Department of Public Health or under other applicable state law.
  - With respect to Inpatient Services for the treatment of alcoholism, Provider means: an accredited or licensed hospital or any public or private facility or portion of that facility providing services especially for the detoxification or rehabilitation of intoxicated persons or alcoholics and which is licensed by the Massachusetts Department of Public Health; or a residential alcohol treatment program, as defined under Massachusetts law or other applicable state law.

- The definition of "Urgent Care" on page A-9 of the 2003 EOC is changed to read as follows:

  Care provided when your health is not in serious danger, but you need immediate medical attention for an unforeseen illness or injury. Examples of illnesses or injuries in which urgent care might be needed are a broken or dislocated toe, a cut that needs stitches but is not actively bleeding, or symptoms of a urinary tract infection.

Need to Write or Call?

Tufts Health Plan
705 Mt. Auburn Street, P.O. Box 9173
Watertown, MA 02471-9173

1-800-870-9488

Commonwealth of Massachusetts
Group Insurance Commission

TUFTS Health Plan

Tufts Health Plan
333 Wyman Street, P.O. Box 9112
Waltham, MA 02454-9112

For additional information,
please call 1-800-870-9488

www.tuftshealthplan.com

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